Senior Service College FELLOWSHIP PROJECT

"FIT TO FIGHT" IS POST TRAUMATIC STRESS DECREASING OUR READINESS?

BY

COLONEL CHARLES HONORE'
United States Army

USAWC CLASS OF 2007

U.S. Army War College, Carlisle Barracks, PA 17013-5050

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. REPORT DATE *(DD-MM-YYYY)*	**2. REPORT TYPE**	**3. DATES COVERED** *(From - To)*
03-03-2007	Civilian Research Paper	14 Aug 2006 – 3 Mar 2007

4. TITLE AND SUBTITLE

"Fit to Fight" Is Post Traumatic Stress Decreasing our Readiness?

5a. CONTRACT NUMBER

5b. GRANT NUMBER

5c. PROGRAM ELEMENT NUMBER

6. AUTHOR(S)

Colonel Charles Honore', USA

5d. PROJECT NUMBER

5e. TASK NUMBER

5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)

The Institute of Advanced Technology
The University of Texas at Austin
3925 West Braker Lane, Suite 400
Austin, Texas 78759-5316

8. PERFORMING ORGANIZATION REPORT NUMBER

IAT.R0471

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)

Mr. Robert Riffle
The Institute of Advanced Technology
The University of Texas at Austin
3925 West Braker Lane, Suite 400
Austin, Texas 78759-5316

10. SPONSOR/MONITOR'S ACRONYM(S)

11. SPONSOR/MONITOR'S REPORT NUMBER(S)

IAT.R471

12. DISTRIBUTION / AVAILABILITY STATEMENT

DISTRIBUTION A: UNLIMITED

13. SUPPLEMENTARY NOTES

The views of the academic research paper are those of the author and do not reflect the official policy of the U.S. Government, the Department of Defense, or any of its agencies.

14. ABSTRACT

This paper examines the Operational Tempo (OPTEMPO) of US forces since Operations Iraqi Freedom and Enduring Freedom. By reviewing historical documentation and troop surveys, it discusses stress impacts to soldiers and family members, including domestic violence, divorce rate trends, and suicide statistics. Finally, the paper examines policies and procedures necessary to effectively manage deployment times, durations to minimize post traumatic stress, and propose recommended changes. Concerns which impact the problem include:

- Force Structure to adequately support the ongoing fight on Global Terrorism,
- Dwell time of redeploying soldiers,
- Follow on assignments of redeploying soldiers,
- Retention / recruitment of quality soldiers.

Leaders have asked more from of their soldiers and family members than they have in more than thirty years. By understanding the impacts that extended deployments have in domestic violence and other potential post traumatic stress symptoms, senior leadership can better emplace measures to care for their most precious resource, their people.

.

15. SUBJECT TERMS

Post Traumatic Stress Disorder (PTSD), Preventive Maintenance Checks and Services (PMCS), Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), Army Force Generation (SRFORGEN), Transients, Trainees, Holdees, and Students (TTHS), Army Medical Surveillance Activity (AMSA)

16. SECURITY CLASSIFICATION OF:			**17. LIMITATION OF ABSTRACT**	**18. NUMBER OF PAGES**	**19a. NAME OF RESPONSIBLE PERSON**
					Bob Riffle/COL Charles Honore'
a. REPORT	**b. ABSTRACT**	**c. THIS PAGE**			**19b. TELEPHONE NUMBER** *(include area code)*
UNCLASSIFED	UNCLASSIFED	UNCLASSIFED	UNLIMITED	20	512-232-4560

Standard Form 298 (Rev. 8-98)
Prescribed by ANSI Std. Z39.18

CIVILIAN RESEARCH PROJECT

"Fit to Fight" Is Post Traumatic Stress Decreasing our Readiness?

by

Colonel Charles Honore'
United States Army

Mr. Robert Riffle
Program Adviser
The University of Texas at Austin

Disclaimer

The views expressed in the academic research paper are those of the author and do not necessarily reflect the official policy or position of the US Government, the Department of Defense, or any of its agencies

US Army War College
CARLISLE BARRACKS, PENNSYLVANIA 17013

ABSTRACT

AUTHOR: COL Charles Honore'

TITLE: "Fit to Fight" Is Post Traumatic Stress Decreasing our Readiness?

FORMAT: Civilian Research Project

DATE: 23 September 2006 WORD COUNT: 5,698 PAGES: 20

CLASSIFICATION: Unclassified

This paper examines the Operational Tempo (OPTEMPO) of US forces since Operations Iraqi Freedom and Enduring Freedom. By reviewing historical documentation and troop surveys, it discusses stress impacts to soldiers and family members, including domestic violence, divorce rate trends, and suicide statistics. Finally, the paper examines policies and procedures necessary to effectively manage deployment times, durations to minimize post traumatic stress, and propose recommended changes. Concerns which impact the problem include:

- Force Structure to adequately support the ongoing fight on Global Terrorism,
- Dwell time of redeploying soldiers,
- Follow on assignments of redeploying soldiers,
- Retention / recruitment of quality soldiers.

Leaders have asked more from of their soldiers and family members than they have in more than thirty years. By understanding the impacts that extended deployments have in domestic violence and other potential post traumatic stress symptoms, senior leadership can better emplace measures to care for their most precious resource, their people.

TABLE OF CONTENTS

ACKNOWLEDGMENTS

This paper is the result of the author's Army War College Fellowship at the Institute for Advanced Technology at The University of Texas at Austin.

"FIT TO FIGHT" IS POST TRAUMATIC STRESS DECREASING OUR READINESS?

Introduction

It is the 22nd of September 2005 in eastern Baghdad, when a patrol from BRAVO Troop 3rd Squadron 7th Cavalry Regiment is preparing for a 0530 hour patrol in Sadr City. The Troop Commander issued the Operation Order (OPORD) and the Troop is preparing for the mission. Intelligence reports of insurgency were distributed and soldiers are expecting upwards of 30 aggressors upon contact. Pre-Combat Checks are in process. Soldiers have conducted Preventive Maintenance Checks and Services (PMCS), under the supervision of their leadership. Squad leaders have inspected the vehicles. Fluid levels are within tolerance, tire pressure is good, weapons mounted and cleaned, windshields are clean, and load plans are in accordance with Troop Standard Operating Procedures (SOP). Soldiers have all required gear. Improved combat helmets are donned, individual weapons cleaned and functioning, load bearing equipment being worn, and gear issued as part of the Rapid Fielding Initiative (RFI) such as Wiley X's for the soldier's eye protection. Squad leaders report to the Platoon Sergeant that the team is REDCON 1.

In order to completely assess the unit's preparedness for the combat operation, other factors must be considered. The mental preparedness of the soldiers requires knowledgeable leaders, who have situation awareness of the changing environment. Leaders must assess individual and collective experiences endured during the deployment. These factors include the length of the deployment, number of deployments, and personal matters, to include marriage and family situations. Leaders have ensured equipment readiness. Soldiers mental state, although not easily evaluated, need equally effective tools to ensure mission success.

Figure 1. Soldiers are continuously exposed to PTSD causing incidences

This paper describes Post Traumatic Stress Disorder (PTSD) and examines the impacts of PTSD on soldiers and family members, including domestic violence, divorce rate trends, and suicide statistics. The research includes survey results of recently re-deployed soldiers and indicates whether the U S Army has adequate force structure to sustain combat operations over time. After examining policies and procedures necessary to effectively manage deployment times and durations to minimize post traumatic stress, I will propose changes to commanders' tools to help identify those soldiers at risk.

Post Traumatic Stress Disorder (PTSD)

The all volunteer forces deployed in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) is the first sustained ground combat operations by the United States since Vietnam. Nearly seventeen percent of OIF and eleven percent of OEF veterans showed symptoms of PTSD, major depression, or severe anxiety [1].

According to sources at the National Institute of Mental Health, PTSD as "is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or human caused disasters, accidents, or military combat" [2]. Symptoms include, but are not limited to flashbacks, nightmares,

panic attacks, feelings of detachment, irritability, trouble concentrating, emotional outbursts and sleeplessness. It is not a disease, rather a reaction to traumatic stress. PTSD was often referred to as "shell shock" or "combat fatigue" during the Vietnam era. According to author Shirley Dicks in her book "From Vietnam to Hell, Few people can understand the pain, loneliness, and stress Vietnam veterans have undergone while serving their country" [3].

As of 3 February 2007, two thousand six hundred and seventy-nine service members have lost their lives to hostile enemy activity in OIF and OEF. Almost ten times that number, twenty-four thousand five hundred and twenty-seven service members have been injured and maimed [4]. For those that have been exposed to trauma, but have escaped physical injury themselves, there is the mental stress caused by the conduct of combat operations. A study published by the New England Journal of Medicine found that one in six veterans of the Iraq war suffers from some form of PTSD or other psychiatric difficulties. Even though the average age of the U.S. fighting soldier is relatively young, without extensive treatment, there exists a high probability for PTSD.

Manning Requirements

The Army Force Generation (ARFORGEN) model is a structured process by which units have an increased readiness posture over time and are better prepared to support Combatant Commanders' deployment requirements. The model is designed to better synchronize resources, including manning and training, in order to deploy whole, cohesive units, capable of executing their mission [5].

According to the methodology, units will receive and train personnel during the Reset and Train Phase within the first year of redeployment in order to conduct individual and collective training culminating in a brigade level training event such as a Mission Rehearsal Exercise. Active component units will then be able to meet the dwell ratio of 1:2, one year deployed, two years at home station, and prepared to again deploy on the 3rd year. Army National Guard and Reserve component organizations will meet a 1:5 dwell ratio, one year deployed and five years demobilized, prepared to deploy on year six [6].

The current Active Army End strength for Fiscal Year 2006 is 505,400 soldiers. This number includes officers and enlisted service members. In Fiscal year 2007, officer

losses are expected to reach 7,297, including those that were retained under the stop / loss program. Officer gains from commissioning institution like the United States Military Academy, Officer Candidate School, the Reserve Officer Training Program and those assessed through special branch gains are expected to reach 8,215 [7].

Enlisted losses through attrition, which includes adverse and administrative losses and desertion is expected to reach 74,003 soldiers. Enlisted gains through recruitment and return of deserters prior to discharge (Return to Military Control) is expected to reach 83,185 soldiers. With a total Active Component expected loss of 81,300 soldiers and a gain expected of 91,400, endstate for Fiscal Year 2007 is anticipated at 515,500 officer and enlisted soldiers [8].

The President of the United States authorized an end strength increase of 20,000 soldiers during his State of the Union Address in January 2007 [9]. Congress approved the temporary increase in the National Defense Authorization Act (NDAA) FY07, funded via Supplemental funds for FY07 and FY08. The authorized Active Army profile will increase the Army to 525K in FY08, 532K in FY09, 539K in FY10, 546K in FY11, and in FY12 an end strength of 547 thousand soldiers.

The authorization level does not guarantee a 100 percent fill of all operational units. Today, there are 63,100 soldiers assigned to the Transients, Trainees, Holdees, and Student (TTHS) account. In 2012, the TTHS account is expected to rise to 69,400 soldiers. The mandated TTHS account level is currently 60K [10]. In addition, the Amy has 3,327 Active Duty Soldiers assigned to Title XI positions, making them temporarily unavailable to meet ongoing deployment needs. The Army must continue to reduce TTHS authorizations in accordance with The National Defense Authorization Act of 2005.

The current manning structure of the Army is not adequately resourced to enable soldiers to meet the requirements of ARFORGEN. General Peter Schoomaker, the Chief of Staff of the Army, has forecasted that U S commitments to Iraq may remain at current levels until 2010. The Army's five year plan would increase the force from a current strength of 505K to a size of 546K. "It is increasingly difficult to keep 150,000 soldiers in the field, fighting year after year, with an active duty force of some 500,000, and not

wear out that force" [11]. Arguably, the right size of the force is about 750,000 soldiers, the size of our force during the Cold War. Not only would it allow the Army to meet the dwell periods between deployments, it would mitigate soldiers from being reassigned from redeploying units to deploying units without the individual training and, at times, the collective training to make them a cohesive element of the organization. It would be impossible to grow the Army to that extent without resorting to conscription. Converting today's all volunteer force into a conscript military would dramatically degrade the effectiveness and professionalism of our Force. Competency would decrease in policing, training of indigenous forces, and counterinsurgency operations; those areas most required in post combat operations [12].

Impacts of Post Traumatic Stress Disorder

PTSD Survey Data and Analysis

The survey was administered to soldiers who had redeployed from OIF within a period of two months to eleven months. The focus of the questionnaire was to examine the effects of PTSD and deployments among OIF veterans. Potential candidates included recent redeployed soldiers, currently serving on active duty, from two Divisions assigned in the Continental United States. Out of the surveys distributed, 92% were completed and returned. The questionnaire asked questions related to deployment and dwell time between deployments, symptoms of PTSD, as well as demographic data. No name or other personal data was required in order to keep confidentiality of the service members.

The questionnaire asked for age of participants. The youngest of the participants was 19 years of age. There were two 50 year olds, making them the oldest of the participants. The average age of all participants was 27 years and 7 months old. Of the fifty percent which experienced symptoms of PTSD, the average age is 28 and ½ years old. Ten percent of those were 40 years of age or older. By eliminating them from the sample, the average age of those experiencing PTSD drops to 26 and ½ years of age.

Rank was based at the time of the questionnaire and was used to determine the range of leadership and leader to led ratio of the participants. The junior ranking soldier was an E-2 (PV2); the senior soldier completing the questionnaire was O-6 (COL). The

majority of the participants served at the grades of E-4 (SPC) and E-5 (SGT). 23% of the participants were leaders at the grade of Sergeant First Class or above. Twenty-one percent of those experiencing PTSD were at the grade of Sergeant First Class or above, with only 8 percent holding officer ranks. Although not limited to junior soldiers, almost 80 percent of those with PTSD symptoms are serving at the Private First Class through Staff Sergeant grades.

Gender was used to determine if significant differences existed among sexes and ability to handle stress. Of all participants, just over 90% were males and the remaining 9.9% were females. Gender breakdown of those experiencing PTSD does not significantly deviate from the sampled population breakdown, with 8.8 percent females and 91.2 percent males displaying symptoms of PTSD.

Branch of service / Specialty was used to determine exposure to combat related incidences across combat arms, combat support, and combat service support branches. In this study, combat arms branches represented 49 percent of the population. Combat support branches represented 20 percent of the population and Combat Service Support branches represented the remaining 31 percent. Although combat arms branches represented forty-nine percent of the sampled population, it represented 56 percent of the population experiencing PTSD. Combat support and combat service support branches deviated slightly from the sample, with 16 percent and 28 percent experiencing symptoms of PTSD respectively. Combat arms specialties continue to bear the brunt of combat stress related incidences.

Marital status was collected to determine the percentage of married participants and divorces which might be attributed to combat deployment. Furthermore, whether the divorce took place during or following the deployment may also be indicative of combat related stress on the marriage. While 64 percent of the questioned population was married prior to the deployment, 28 percent of the married population divorced. Of those divorced service members, 31 percent were divorced prior to deploying. Nineteen percent were divorced following the deployment and half (50%) were divorced or separated during the deployment. While females only represented 9.9 percent of the sampled population, they represented 19 percent of the divorced population.

Length in service was used to assess the potential of senior personnel to handle combat related stress better than those with fewer years and less rank. The soldier with the shortest time in service served for 1 year at the time of the questionnaire. The soldier with the longest time in service has served for 30 years. The average time of service across the questioned population at the time of the survey was 7.13 years. The length of service of the population experiencing PTSD averaged 7.8 years of service, slightly higher than the average time in service of the sampled population. If the officers are eliminated (8% of the population) from the equation, the average time in service of those with PTSD drops to 7.3 years.

The soldiers were asked if they smoked cigarettes. This data was used to determine vulnerability of soldiers to begin smoking while deployed. In this study, forty-four percent of the questioned population smoked cigarettes. 10 percent of that group began smoking while on deployment. The data shows that although a higher percentage of males smoke than females, percentages were insignificant across gender lines. Although 44 percent of the sampled population smokes cigarettes, 55 percent of those experiencing symptoms of PTSD are smokers. Of note, all of the soldiers who began smoking during the deployment have experienced combat stress related symptoms, except one.

The number of combat deployments soldiers participated in was used to determine the percentage of the questioned population which had more than one deployment. Sixty percent have been deployed once, 32 percent have deployed twice, and 8 percent of those questioned have deployed more than twice. One soldier has been deployed to combat 4 times throughout his career. Although the sample showed that 60 percent of the soldiers questioned deployed once, they represented only 48 percent of those experiencing PTSD. Two time deployers represented 32 percent of the sample, but 42 percent of those with PTSD. Of those with more than two deployments (8%), 11 percent experienced symptoms of PTSD.

Soldiers with multiple deployments were asked if they deployed with different units. This information will indicate the number of soldiers that were reassigned from a redeploying unit to a deploying unit. Of the 40% who had multiple deployments in this

study, 80% of them had deployed with more than one unit. Of the 32 percent of the sampled population that had multiple deployments with multiple units, 43 percent experienced PTSD. Being reassigned from redeploying units to deploying units may be a contributor to combat stress related incidences.

Total time deployed might indicate a correlation between total time away from family, time exposed in a combat environment, and PTSD indications. The shortest total time deployed by a soldier was 6 months. The longest total deployment time was 4 years. The average deployment time for the population was 1 year and 6 months. Total deployment time for those with symptoms of PTSD closely resembles that of the sampled population. The frequency of PTSD increases with the frequency of deployments, thereby increasing time away from families. Surprisingly, the questionnaire does not indicate any correlation to total time deployed and divorce rates.

Dwell time is the period of time back at home station between deployments. This data was used to determine the average duration between combat deployments and correlation to combat stress. For the population questioned, the shortest dwell period was 4 months. The longest dwell period was 4 years, while the average for the population was 1 year and 4 months. Those with multiple deployments and experiencing symptoms of PTSD averaged a dwell period of 1.4 years at home station prior to again deploying. The average dwell did not change for those not experiencing PTSD, therefore, no conclusive evidence from this survey exists that increased dwell time will lead to a decrease in PTSD. We can, however, say that decreased dwell periods are having significant negative effects on our soldiers.

Finally, soldiers were asked if they had or were currently experiencing one or more PTSD symptoms, including signs of sleeplessness, nightmares, flashbacks or feelings of detachment. Fifty percent of those questioned experienced one or more of the symptoms. Figure 1 depicts the demographics of the sample group and the analysis of those with symptoms of PTSD.

Figure 1 displays the requests for information across both the surveyed population and the fifty percent of those experiencing PTSD.

Figure 2. Soldier Survey Requests for Information.

REQUEST FOR INFORMATION	SURVEY POPULATION	POPULATION EXPERIENCING PTSD
Age	Youngest - 19, Average - 27, Oldest - 50	Average - 28.5 years old
Rank	Junior - E-2, Average- E-4/5, Senior - O6	21% E-7 - COL, 79% E-3 - E-6
Gender	Male - 90.1% Female - 9.9%	Male - 91.2% Female - 8.8%
Branch of service / specialty	CA – 49% CS – 20% CSS – 31%	CA – 56% CS – 16% CSS – 28%
Marital status	Married – 64% Divorced / Separated – 28%	Married – 78% Divorced / Separated – 22%
Time in service	Shortest – 1 yr Avg – 7.13 yrs Longest – 30 yrs	Average – 7.8 yrs
If divorced, when? (Prior to, during, after deployment)	Before – 31% During – 50% After – 19%	Before – 35% During – 45% After – 20%
Smoke cigarettes?	Yes – 44%	55% with PTSD are smokers
Smoke prior to deployment?	Yes – 90% No – 10%	48% with PTSD smoked prior to deployment
Number of combat deployments	1 – 60% 2 – 32% 3 or more – 8%	1 – 48% 2 – 42% 3 or more – 11%
Number of units deployed with (multiple deployers)	1 – 68% 2 or more – 32%	43% of multiple deployers with multiple units
Number of years deployed (total)	Shortest – 6 mos Average – 1 yr, 6 mos Longest – 4 yrs	Average – 1 yr, 6 mos
Dwell time (for multiple deployers)	Shortest – 4 mos Average – 1 yr, 4 mos Longest – 4 yrs	Average – 1 yr, 3 mos
Symptoms of PTSD	50%	

Domestic Violence

Domestic violence rates have increased in the military from 18.6 percent per 1000 to 25.6 per 1000 between 1990 an 1996. During that period, 23.2 percent per 1000 military spouses have experienced a violent victimization. In 2001 alone, there were 18,000 reported cases of abuse on military spouses. Of which, some 11,000 were substantiated [13]. According to "The War at Home; 60 Minutes," violence rates of marital aggression are three to five times that of civilian rates. When attempting to

identify soldiers who are at risk of committing violence against family members, the following factors need to be considered; victims of domestic violence are predominantly female, less than 25 years old, and married to an active duty soldier. They have been married for less than two years on the average and seventy-eight percent have children. The majority of them (52%) live outside of government quarters [14]. Physical abuse is prevalent among substantiated cases, making up eighty-five percent of the cases. It's fair to say that although not always the case, the majority of the offenders are less than model soldiers. They are less likely to be promoted and more likely to be separated from the Army.

Although sexual assault in the military is estimated at approximately seven percent, eight percent of female service members who are veterans of the Persian Gulf War reported being sexually abused during the deployment. In addition, thirty percent of female veterans reported either being raped or attempted rape while on active duty [15].

Divorce Rates

During Vietnam, an estimated forty percent of male war veterans were divorced at least once. Those with PTSD tend to experience more marital and family problems [16], with twenty three percent experiencing parenting problems.

The divorce rate among Army Officers increased dramatically in Fiscal Year 2004, the height of Operation Iraqi Freedom and Operation Enduring Freedom. The FY03 rate of 3.3 percent rose to 6.0 percent, and for the first time, exceeded the Army Enlisted divorce rate of 3.5 percent.

Dual military marriages suffer higher rates of divorce. In FY05, male officers in dual military marriages divorced at a rate of 2.7 percent while enlisted males, also in dual military marriages, divorced at a rate of 5.3 percent. Female officers in a dual military marriage divorced at a rate of 3.3 percent for officers and 5.7 percent for enlisted females. Military males married to civilian members divorced at a rate of 1.6 percent for officers and 2.5 percent for enlisted.

Female soldiers in civilian marriages had a significant higher divorce rate of 5 percent for officers and 9.7 percent in the enlisted female grades.

By gender and rank, active duty females had a higher divorce rate than active duty males. Enlisted females had a divorce rate of 8.3 percent in FY06, compared to a 2.6 percent divorce rate for enlisted males during the same period. Female officers serving on active duty more than doubled the male officer divorce rate with a rate of 4.1 percent compared to 1.4 percent [17].

Figure 2 is a comparison of divorce rates between officers and enlisted personnel, deployed in support of OIF and not deployed.

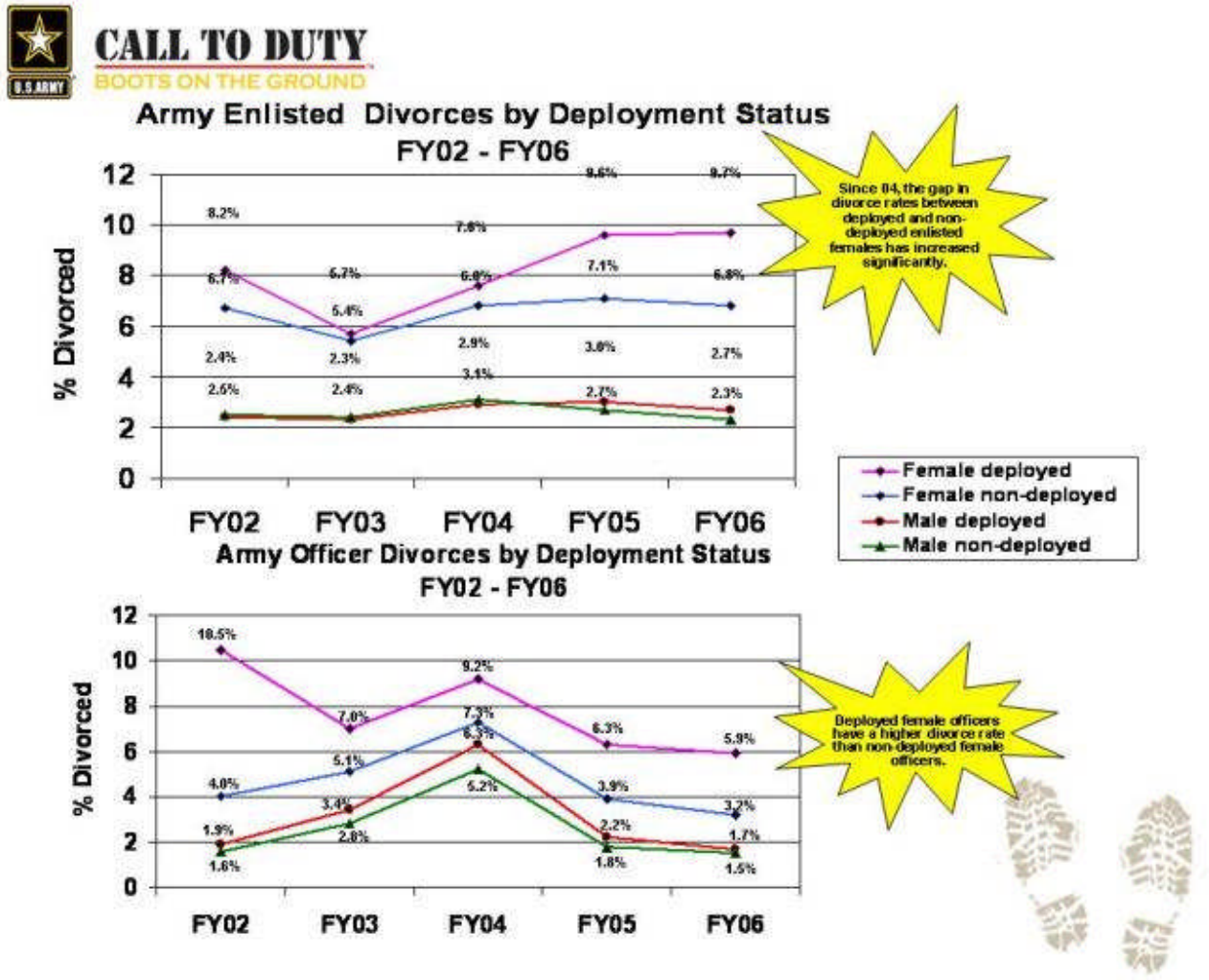

Figure 3. Army Divorce Trends.

Suicide Statistics

Suicides have been on the increase in recent years, with rates higher since the beginning of Operation Iraqi Freedom than ever before. The Army's leadership continues to study the rising rates and ways to mitigate stressors associated with suicide. In 2000, the Army's suicide rate was 12.1 per 100,000 soldiers. With a slight decline in rate of 9.2 per 100,000, it again rose to 11.3 and 12.2 per 100,000 soldiers in 2002 and 2003 respectively. In 2006, the Army experienced 100 suicides, the highest number since 1991. This compares to a total of 88 suicides in calendar year 2005. The regular Army rate for 2006 is 18.5 per 100,000 soldiers, the highest rate in the past 25 years in the military.

Soldiers deployed in support of Operation Iraqi Freedom experienced a rate of suicide of 18.8 per 100,000 soldiers, significantly higher than the Army rate. In 2005, OIF soldiers accounted for 19.9 per 100,000 compared to an Army rate of 13.0. Deployment lengths and family separations are two of the contributing factors linked to the increased rates [18].

Although there is no compelling evidence that there is a correlation between PTSD and suicides, it is factual that the suicide rate among soldiers supporting OIF nearly doubled in 2005, and soldiers that have deployed more than once report higher levels of anxiety and depression than those serving first tours.

Figure 3 depicts the Army suicide rates compared to that of soldiers deployed in support of OIF between the years 2000 to 2006.

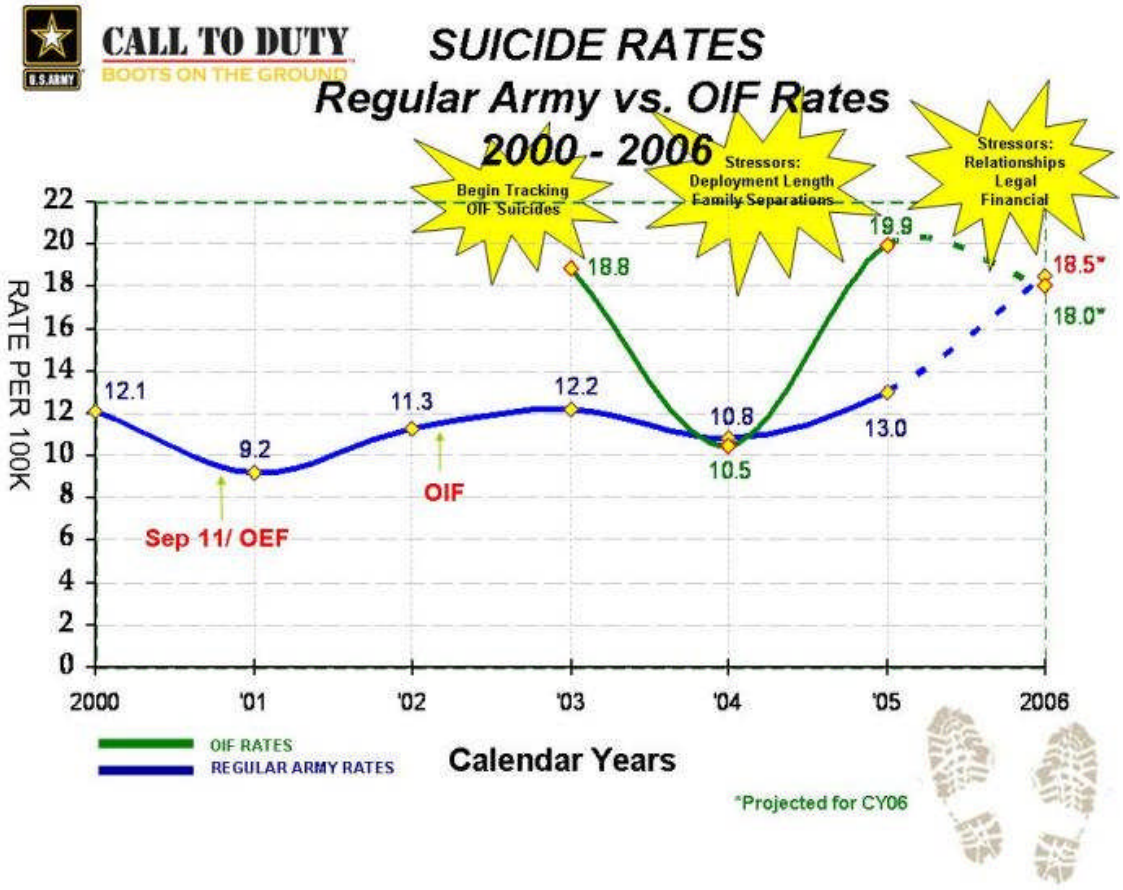

Figure 4. Army Suicide Rates.

Commanders Tools to Address PTSD

Reintegration Training

Realizing the magnitude of stress caused by combat deployments on the soldier, the Army provides programs and services to soldiers, civilians and Army families upon redeployment to reduce stress and help families deal with potential issues which may arise. One such program is Reintegration training. Prior to soldiers taking a much deserved leave of absence following redeployment, soldiers must attend the Military Reintegration Training designed to assist soldiers in managing emotions gathered from experiences in a combat zone and to reunite them with family members and friends back at home station. The program of instruction covers:

- *Stress on and off the battlefield.*
- *Marriage communication.*
- *Communication with your children.*
- *Anger Management workshop.*
- *Single parent reintegration workshop.*
- *Single soldier reintegration workshop.*
- *Money Management workshop.*
- *Divorce recovery workshop.*

Redeploying organizations send qualified personnel, usually Chaplains assigned to the organization, to required training in order to certify them as qualified reintegration instructors. Soldiers are required to attend the training with their spouse if available. Since, often, PTSD does not show until months following redeployment, soldiers may show no symptoms of PTSD and are likely not to actively participate in training.

Outsource Reintegration Training: To make this more than a "check the box" exercise, we must consider taking the instructor requirement away from the "green suiter" and hiring highly trained civilian professionals, capable of drawing emotions out of the participants. Getting those not affiliated with the Army will make soldiers and family members more at ease and make it an interactive session instead of another "block of instruction."

Marriage workshops conducted quarterly: According to the article "Unseen Scars" in the 1 January 2007 edition of Army Times Magazine, "the number of troops reporting PTSD or depression was relatively low when they were first surveyed but increased by 200 percent after they were home for four months" [19]. Marriage Communications and the Divorce recovery workshops need to be mandatorily provided to soldiers and spouses at time of redeployment and up to six months afterwards. In addition, the anger management, communication with children, and single parenting workshops should become reoccurring events conducted quarterly.

Post Deployment Health Assessments

The Post Deployment Health Assessment is a commander's program designed to ensure redeploying personnel are able to make a smooth post-deployment transition. During the redeployment process, commanders must ensure that returning individuals conduct a face to face assessment with a trained health care provider; that being either a physician, a physician's assistant, a nurse practitioner, or an independent medical technician. The trained professional will include in his / her assessment [20]:

- Soldiers' responses to the health assessment DD Form 2796.
- Mental health or psychosocial issues.
- Medications taken while deployed.
- Possible environmental or occupational exposure concerns.

The DD Form 2796 must be completed in theater, within five days of redeploying to home station. It must be both administered and immediately reviewed by a health care provider. The provider can be a medic assigned to the unit, but when positive responses are identified, they must be immediately referred to a physician or another trained health care provider identified earlier. The original assessment must be placed in the permanent medical record of the soldier, and copies forwarded to the Army Medical Surveillance Activity (AMSA) for analysis and reporting requirements [21].

The Post Deployment Assessment Worksheet (DD Form 2796) is a useful self assessment of redeploying soldiers. It begins with administrative data to include name, gender, branch of service, and location of deployment. The following section, questions 1 – 6 address current medical status, to include number of visits to sick call, vaccinations received during the deployment, and symptoms of sickness both during the deployment and currently. Questions 7 – 13 ask questions related to exposure to dead or wounded personnel, feelings of depression and family and friend relationship concerns. The self assessment closes with questions of exposure to chemical, biological, radiological warfare agents as well as potentially harmful industrial solvents on questions 14 - 18.

Because of the stigma associated with mental illness, soldiers are hesitant to admit to any symptoms PTSD in fear that it could damage their careers. Supervisors often have

insights to combat experiences and levels of stress among his / her soldiers; however, there is no formal process for supervisory input.

DD Form 2796 Modification: Add a block at the bottom of the Post Deployment Health Assessment for supervisory input, the assessment would become a more useful tool for both commanders and medical professionals. Again, since PTSD often surfaces four to six months following redeployments, continuous assessments would be useful after having been home for 90 to 120 days.

Conclusion

Estimates for those experiencing PTSD are conservative because military personnel are hesitant to report it in fear that the admission of seeking mental health services will ruin their careers. By definition, it could be argued that the majority of redeploying soldiers are or will suffer from PTSD. The impact to our soldiers and their families is increased domestic violence and divorce trends. Although increases in suicides throughout the force cannot be directly attributed to PTSD, suicides while deployed are on the rise and certainly a result of combat related stress.

Divorce rates tend to be higher among enlisted military members than officers except for the spike in FY04. Females divorce statistics have tripled those of males for both military officers and enlisted personnel. Although male divorce rates in dual military marriages were higher than those where the spouse was a civilian, it did not reach rates of female soldiers, whether married to another service member or not.

Single soldiers account for 62 percent of the 2006 suicides and 52 percent over the past three years. Suicides are committed with firearms in 74 percent of the cases. Soldiers at the grades of E-1 (Private) through E-4 (Specialist) committed 65 percent of the suicides in 2006. High troop density areas account for the preponderance of suicides. Fort Hood, Fort Lewis, and Germany account 18 percent, 10 percent, and 8 percent of suicides respectively. Thirty nine percent of suicides occur in one quarter of the year. In 2006, twenty-eight suicides were committed in the months of April, May, and June.

Tailor prevention programs: The Army Suicide Prevention Program has to develop relevant and tailored programs, targeted at soldiers assigned to those areas where high risk soldiers are assigned. Commanders and supervisors must identify those soldiers

experiencing symptoms associated with suicide and stress associated with separation and deployment length. They must use the Army Suicide Event Report as a tool to train Unit Behavioral Health Needs Assessment Teams to properly assess deployed soldiers and provide timely care.

Identify soldiers at risk: The soldier questionnaire indicates that high risk soldiers include those between the ages of 26 and 28 years old, hold the rank of Private First Class through Staff Sergeant, and are in a combat arms specialty. Those that began smoking while deployed are more susceptible to PTSD. Females have a higher chance of being divorced than males and likelihood of PTSD increases with number of deployments. By identifying the high risk service members, marriage counseling initiatives and other Army Well Being Programs can be better tailored to focus on vulnerable military members and family members encouraging continued military service. Modular programs to deal with challenges of joint military families and programs specifically focused on female and younger soldiers are required to build stronger bonds among military families.

Reoccurring Post Deployment Health Assessments: Post Deployment Health Assessments must be conducted routinely to identify potential combat related issues since symptoms do not always occur immediately upon redeployment. The Post Deployment Health Re-assessment is a step in the right direction, designed to extend the window of outreach and referral for those who develop PTSD after being home for some time. When administered quarterly to soldiers, reintegration training can then be redirected to those in need and refocused to care for the particular issues and concerns.

The Army is not currently manned to adequately mitigate risks to the soldier and the force. Without a drastic change in the methodology that we train the force, it will be difficult to maintain a TTHS goal of 60,000 soldiers, negatively impacting to fill rates of our operational force. The result will be soldiers redeploying to combat with less than an acceptable dwell time between deployments.

Permanent Force Structure Approval: The 20K temporary authority, to grow the Force to 532,400 soldiers, expires in FY09. In order to achieve an acceptable

deployment to dwell ratio of 1:2, as outlined in the ARFORGEN model, the National Defense Authorization Act must be changed to make strength projections permanent.

Bringing back the "draft" (conscription) is not an option that either our political leadership or American people are prepared to support. Our President and Congressional leaders should make a call to national service. That, along with the attractive recruitment and retention incentives, will help the Army continue to exceed the re-up objectives, and recruit to a larger endstrength over the next several years.

The success of the patrol in Sadr City in September 2005 was a result of leadership ensuring conditions for success were established and met. By understanding the vulnerabilities of the soldiers, leaders can determine the mental readiness of the soldiers, just as they did the readiness of the equipment. With the implementation of a permanent force structure change, approving the temporary 20K authorization, thereby decreasing frequency of deployments and increasing dwell periods, our Army can better meet the ARFORGEN model. Coupled with the effective use of the Post Deployment Health Assessment and tailored Reintegration training period, focused on high risk soldiers and extended to identify PTSD symptoms up to 180 days following redeployment, our commanders can mitigate the impacts of PTSD on their formations.

REFERENCES

1. "Unseen Scars," Army Times Magazine: 1 January 2007

2. National Institute of Mental Health, Post-Traumatic Stress Disorder (PTSD)

3. Dicks, Shirley, From Vietnam to Hell: Interviews with victims of Post Traumatic Stress Disorder, McFarland & Company Inc. 1990 p. 2-3.

4. Global War on Terrorism, Defense Manpower Data Center Statistical Information Analysis Division, 3 Feb, 2007

5. 2007 U.S Army Posture Statement / Addendum H: Army Force Generation

6. IBID

7. IBID

8. IBID

9. Bush, George W., State of the Union Address, January 2007

10. Call to Duty briefing, Boots on the Ground, www.us.army.mil

11. Boot, Max and O'hanlon, Michael, Create a U S Foreign Legion, Armed Forces JournalMarch 2007, pgs 11-16

12. IBID

13. The Miles Foundation, Domestic Violence in the Military

14. IBID

15. IBID

16. Dicks, Shirley, From Vietnam to Hell: Interviews with victims of Post Traumatic Stress Disorder, McFarland & Company Inc. 1990 p. 2-3.

17. Call to Duty briefing, Boots on the Ground, www.us.army.mil

18. IBID

19. "Unseen Scars," Army Times Magazine: 1 January 2007, page 14

20. MEMO FOR COMBATANT COMMANDERS, Enhanced Post Deployment Health assessments, 22 April 2003

21. MEMORANDUM, Office of the Chairman, Updated Procedures for Deployment Health Surveillance and Readiness, 1 February 2002, Enclosure F, Post Deployment Health Assessment Form (DD Form 2796) Processing Guidance